Mohammed Ahmad, MD

PATIENT REGISTRATION

PATIENT INFORMATION (Please list all names and nicknames) Today's Date:_____

Last Name:_____ First Name:_____ Middle Initial:_____

Street Address:_____ Apt./Suite No._____ P.O. Box_____

City:_____ State:_____ Zip Code:_____ Home: (_____)_____-_____

Cell: (_____)_____-_____ Facebook name/Twitter Handle_____ **May we, or our authorized agents, leave a message or contact you electronically regarding your care, scheduling, follow-up, and billing? ☐ Yes ☐ No** Initial_____ **If no, which number may we, or our authorized agents, utilize regarding payment? (_____)_____-_____**

Date of Birth: _____/_____/_____ Social Security #:_____ Email Address:_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Employment: ☐ Full-Time ☐ Part– Time ☐ Unemployed

Employer Name and Position with company:_____ Phone #:(_____)_____-_____

Emergency Contact Name:_____ Phone #:(_____)_____-_____

Primary Care Physician:_____ Phone #:(_____)_____-_____

If applicable, please list spouse:_____Phone #:(_____)_____-_____

Is this an on-the-job or WORK-RELATED injury? ☐ Yes ☐ No If yes, complete the following:

Date of Injury:_____ Worker's Compensation Claim #:_____

Name of Attorney:_____ Phone #:(_____)_____-_____

Is today's visit the result of injuries sustained in a MOTOR VEHICLE ACCIDENT? ☐ Yes ☐ No If yes, complete the following:

Date of Injury:_____ Insurance Company:_____ Claim #:_____

Name of Attorney:_____ Phone #:(_____)_____-_____

GUARANTOR INFORMATION: (List person **RESPONSIBLE FOR BILL IF OTHER THAN PATIENT**– Please list all names and aliases) - **GUARANTOR MUST BE PRESENT**

If over 18 years of age, please indicate if billing statements should be mailed to responsible party: ☐ Yes ☐ No Initial_____

Relationship of Guarantor to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Last Name:_____ First Name_____ Middle Initial:_____

Mailing Address:_____ Apt./Suite No._____

City:_____ State:_____ Zip Code:_____

Home:(_____)_____-_____ Cell:(_____)_____-_____ Work:(_____)_____-_____

Date of Birth:_____/_____/_____ Social Security #:_____ Email Address:_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer Name, Position, Address_____

INSURANCE INFORMATION: MUST PROVIDE INSURANCE CARDS TO RECEPTIONIST TO PHOTOCOPY

IF SOMEONE OTHER THAN PATIENT IS THE POLICY HOLDER, PLEASE INCLUDE POLICY HOLDER'S DATE OF BIRTH

PRIMARY INSURANCE: _____ Policy ID #:_____ Group #:_____

Policy Holder's Name (Last name first):_____ Date of Birth:____/____/_____ Social Security #:_____

SECONDARY INSURANCE:_____ Policy ID #:_____ Group #:_____

Policy Holder's Name (Last name first):_____ Date of Birth:____/____/_____ Social Security #:_____

REFERRAL INFORMATION: Were you referred by a physician? ☐ Yes ☐ No If yes, Name of Physician and phone #_____

How did you hear about us? Physician Insur- ☐ ance ☐ Company Em- ☐ ployer ☐ Attorney ☐ Friend ☐ Website ☐ Internet ☐ Drive-by ☐ Print Ad Other_____

I certify that the information provided is correct to the best of my knowledge. I will not hold Mohammed Ahmad, MD, it's health providers, or it's employees responsible for any errors or omissions that I may have made in completing the information on this form.

Ø_____ Date:_____